U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OFFICE OF MANAGEMENT AND BUDGET
PAPERWORK REDUCTION ACT
CLEARANCE PACKAGE

SUPPORTING STATEMENT-PART A

REVISION OF THE MINIMUM DATA SET (MDS) 3.0 (v1.18.11)
NURSING HOME AND SWING BED PROSPECTIVE PAYMENT SYSTEM (PPS)
FOR THE COLLECTION OF DATA
PERTAINING TO THE
PATIENT DRIVEN PAYMENT MODEL (PDPM) & THE SKILLED NURSING FACILITY
QUALITY REPORTING PROGRAM (QRP)

SUPPORTING STATEMENT-PART A

MDS 3.0
FOR THE COLLECTION OF DATA PERTAINING TO
THE PDPM AND SNF QRP

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Supporting Statement A
Minimum Data Set 3.0 Nursing Home and Swing Bed Prospective Payment System (PPS)
For the collection of data related to the Patient Driven Payment Model and the Skilled Nursing Facility Quality Reporting Program (QRP)
CMS-10387, OMB 0938-1140

This package is a request for a revision to the current Minimum Data Set (MDS) assessment instrument for the Skilled Nursing Facility (SNF). This package represents a request from the Centers for Medicare & Medicaid Services (CMS) to implement the MDS 3.0 v1.18.11 beginning October 1, 2023 to October 1, 2026 in order to meet the requirements of policies finalized in the Federal Fiscal Year (FY) 2020 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) final rule (CMS-1718-F, RIN 0938-AT75). A PRA package was submitted at the time of the finalized policies and approved on 11/22/2019, but the compliance date for the finalized policies (10/01/2020) was delayed due to the COVID-19 public health emergency (PHE).[1] Please note, however, the burden was never retracted, and the implementation of the instrument was simply delayed. While there has been no change in assessment-level burden since the approval of the MDS 3.0 v1.17.2, there has been a change in total burden since 2019 when the package was originally approved due to a decrease in the number of MDS assessments completed and a change in the hourly rate for clinicians completing the assessment.

The package submitted with the FY 2020 SNF PPS final rule described the assessment tool changes associated with the policies finalized in the FY 2020 SNF PPS final rule, and are summarized here and in the document included with the package, titled *Draft MDS 3.0 Item Set Change History v1.18.11 Oct 2023.pdf*:

- REMOVED: These items present in v1.17.2 are not present in v1.18.11.

A0300	A1000	D0200	G0100A	G0110B
G0110C	G0110D	G0110E	G0110F	G0110G
G0110H	G0110I	G0120	G0300	G0900
J0500	N0410	O0600	O0700	

- REVISED: These items' language was slightly revised to align across the post-acute care settings and now have new item numbers in v1.18.11, but do not represent 'new' burden for the v1.18.11.

A1100 to A1110	A1800 to A1805	A2100 to A2105	D0300 to D0160
G0110J to GG0130I	G0400 to GG0115	G0600 to GG0120	J0400 to J0410
K0520	N0415	O0100 to O0110	Q0300 to Q0310
Q0600 to Q0610			

- NEW: These items are new to the v1.18.11, and were included in the original PRA package approved November 22, 2019.

A1005	A1010	A1250	A2121	A2122
A2123	A2124	B1300	D0150	D0700
GG0170FF	J0510	J0520	J0530	Q0500C
Q0550C	Q0620			

[1] The interim final rule with comment period that appeared in the May 9, 2020 Federal Register (85 FR 27550) delayed the compliance date for certain reporting requirements under the SNF QRP (85 FR 27596 through 27597).

A. Background

1. Background of the MDS in Nursing Homes (NH)

The MDS is a uniform instrument used in every Medicare/Medicaid certified nursing home in the United States to assess resident condition. It was developed in response to the Landmark Institute of Medicine (IOM) Report on Nursing Home Quality in 1987 where the MDS was seen as a critical component in efforts to improve the quality of care in nursing homes. From its inception, the MDS was intended to serve several purposes:

(1) Collect data to inform care plans
(2) To generate quality indicators to evaluate nursing homes and guide improvement interventions
(3) To serve as a data source for nursing home payment systems.

Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA), but it has been determined that requirements for SNF staff performing, encoding and transmitting patient assessment data necessary to administer the payment rate methodology described in 413.337, are subject to the PRA.

The SNF QRP was established in CMS-1622-F (August 4, 2015; 80 FR 46390) and began collecting data from SNFs in FY 2016 using the MDS.

Regarding the SNF Quality Reporting Program (SNF QRP), **Table 1** lists the quality measures, collected via the MDS, currently in use.

Table 1: Quality Measures Currently Collected via the MDS

Quality Measures Currently Adopted for the FY 2023 SNF QRP Short Name	Measure Name & Data Source
Resident Assessment Instrument Minimum Data Set	
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury.
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674).
Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).
DRR	Drug Regimen Review Conducted With Follow-Up for Identified Issues- Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP).

Both the Patient Driven Payment Model (PDPM) in the SNF PPS and the SNF QRP collect data through the MDS 3.0. The PDPM was described and adopted for SNFs and Swing Beds in CMS-1696-F (August 8, 2018; 83 FR 39162).

2. Background of this PRA Package

This package is a request for a revision to the current MDS assessment instrument for the SNF and is associated with the August 7, 2019 (84 FR 38728) "Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2020" final rule (CMS-1718-F, RIN 0938-AT75) that finalized policies for collection of Transfer of Health (TOH) Information measures and certain standardized patient assessment data elements. At the time of the finalized policies, a PRA package was submitted for the item set and approved on 11/22/2019. However, in response to the COVID-19 PHE, the compliance date for the finalized policies (10/01/2020) was delayed due to the COVID-19 PHE,[2] and CMS subsequently requested a non-substantive change to extend the use of the MDS 3.0 v1.17.1 instrument on September 25, 2020. Please note, however, the burden approved on 11/22/2019 was never retracted, and the implementation of the instrument was simply delayed.

On August 3, 2022, CMS finalized a proposal to revise the compliance date for the collection of the TOH Information measures and certain standardized patient assessment data elements from two full fiscal years after the end of the COVID-19 PHE[3] to October 1, 2023 (87 FR 47551).

On November 22, 2022, OMB approved MDS 3.0 v1.17.2. This revision to the MDS was in response to request for stae\te agencies to add the PDPM payment items to OBRA assessments so they could collect the data and use it to develop their future payment models. OBRA assessments are PRA exempt so the burden did not increase from MDS v3.0 v1.17.1 to MDS 3.0 v1.17.2. While there has been no change in assessment-level burden since the approval of the MDS 3.0 v1.17.2, there has been a change in total burden. Since the original package was submitted and approved three years ago, there has been a decrease in the number of MDS assessments completed by providers as well as a change in the hourly rate for those clinician types completing the assessment. Therefore, this package does represent a revision to the previous information collection request (ICR).

B. Justification

1. Need and Legal Basis

Pursuant to sections 4204(b) and 4214(d) of OBRA 1987, the current requirements related to the submission and retention of resident assessment data are not subject to the Paperwork Reduction Act (PRA), but it has been determined that requirements for SNF staff performing, encoding and transmitting patient assessment data for the PPS 5-day (NP item set) and PPS discharge (NPE

[2] The interim final rule with comment period that appeared in the May 9, 2020 Federal Register (85 FR 27550) delayed the compliance date for certain reporting requirements under the SNF QRP (85 FR 27596 through 27597).
[3] The interim final rule with comment period that appeared in the May 9, 2020 Federal Register (85 FR 27550) delayed the compliance date for certain reporting requirements under the SNF QRP (85 FR 27596 through 27597).

item set) assessments, necessary to administer the payment rate methodology described in 413.337, are subject to the PRA.

Section 1888(e)(6)(B)(i)(II) of the Act requires that each SNF submit, for FYs beginning on or after the specified application date (as defined in section 1899B(a)(2)(E) of the Act), data on quality measures specified under section 1899B(c)(1) of the Act and data on resource use and other measures specified under section 1899B(d)(1) of the Act in a manner and within the timeframes specified by the Secretary. In addition, section 1888(e)(6)(B)(i)(III) of the Act requires, for FYs beginning on or after October 1, 2018, that each SNF submit standardized patient assessment data required under section 1899B(b)(1) of the Act in a manner and within the timeframes specified by the Secretary. Section 1888(e)(6)(A)(i) of the Act requires that, for FYs beginning with FY 2018, if a SNF does not submit data, as applicable, on quality and resource use and other measures in accordance with section 1888(e)(6)(B)(i)(II) of the Act and standardized patient assessment in accordance with section 1888(e)(6)(B)(i)(III) of the Act for such FY, the Secretary reduce the market basket percentage described in section 1888(e)(5)(B)(ii) of the Act by 2 percentage points.

Section 2(a) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act amended the Social Security Act (the Act) by adding section 1899B to the Act, which requires, among other things, SNFs to report standardized patient assessment data, data on quality measures, and data on resource use and other measures. Under section 1899B(m) of the Act, modifications to the SNF assessment instrument, here the MDS, required to achieve standardization of patient assessment data are exempt from PRA requirements. Standardization has been met upon our adoption of the proposed data elements and standardized patient assessment data in CMS-1718-F. For FY 2020 and thereafter, the exemption of the SNF QRP from the PRA is no longer applicable such that the SNF QRP requirements and burden will be submitted to OMB for review and approval. The active ICR serves as the basis for which we now address the previously exempt requirements and burden.

2. Information Users

CMS uses the MDS 3.0 PPS Item Set to collect the data used to reimburse skilled nursing facilities for SNF-level care furnished to Medicare beneficiaries and to collect information for quality measures and standardized patient assessment data under the SNF QRP.

The public display of quality measure data by CMS imposes no additional burden on SNFs.

3. Improved Information Technology

CMS has developed customized software that allows skilled nursing facilities to encode, store and transmit MDS 3.0 data. The software is available free of charge, and CMS provides customer support for software and transmission problems encountered by the providers.

4. Duplication of Similar Information

The data required for reimbursement and for the SNF QRP are not currently available from any other source.

5. Small Entities

As part of our PRA analysis for an extension of our existing approval, we considered whether the change impacts a significant number of small entities. In this filing we utilized the instructions that pertain to the Paperwork Reduction Act Submission Worksheet, Part II to determine the number of small entities. Specifically, a small entity can be defined as a small organization that is any not-for-profit enterprise that is independently owned and operated and is not dominant in its field. Data indicate that in 2021, 23% of the total SNF number were non-profit. This equates to 3,558 non-profit SNFs.

6. Collection Frequency

Under the PDPM payment system we need to collect this information at the required frequency, that is at the start of a resident's Part A SNF stay to classify the resident into a payment category, and upon discharge from a SNF stay for monitoring purposes. For the SNF QRP, the data collection time points and data collection frequency are consistent with the PDPM payment system. Data is collected for the SNF QRP both at the start of a resident's Part A SNF stay and upon discharge from a resident's Part A SNF stay in order to calculate the quality measures adopted under the SNF QRP and to obtain standardized patient assessment data.

7. Special Circumstances

There are no special circumstances that would require the PPS 5-Day and PPS discharge assessments to be conducted more than once during a resident's stay.

8. Federal Register Notice/Outside Consultation

The 60-day Federal Register notice published February 7, 2023 (88 FR 7976. There were no public comments received.

The 30-day Federal Register notice published April 18, 2023 (88 FR 23679).

9. Payment/Gift to Respondent

There were no gifts and no payment to respondents.

10. Confidentiality

To address concerns about confidentiality of resident data, we provide that a facility and a State may not release resident-identifiable information to the public, and may not release the information to an agent or contractor without certain safeguards (42 CFR 483.20(f)(5) and 483.315(j)).

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimate (Total Hours & Wages)

The active information collection request (approved November 22, 2022) sets out burden estimates for the item sets NP, NPE, and IPA, which are the item sets used for the PDPM. The item sets NOD, NO/SO, NSD, and NS/SS, included in the PRA disclosure statement on page two of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (found at: https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf), were discontinued for payment purposes as of 10/1/2019, when the PDPM took effect. However, we continue to use the number of items (272) on the OMRA (NO/SO) item set as a proxy for all assessments, consistent with the active information collection request.

We have updated the MDS burden estimates on skilled nursing facilities. The assessment-level burden hours approved for the previous version MDS 3.0 v1.17.2 remain intact in the estimate. However, we used FY 2021 data to calculate the frequency and number of assessments completed, and updated the salary estimate using the U.S. Bureau of Labor Statistics (BLS) from May 2018 to May 2020. As a result, the total burden has decreased. We provide additional details about the changes in Section 15 of this package

Wage Estimates

To derive average costs, we used data from the U.S. BLS May 2020 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). The following table presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	Occupation Code	Mean Hourly Wage ($/hr)	Fringe Benefits and Overhead ($/hr)	Adjusted Hourly Wage ($/hr)
Health Information Technician	29-2098	23.21	23.21	46.42
Registered Nurse	29-1141	38.47	38.47	76.94

For *preparation functions*, we used the adjusted registered nurse wage of $76.94/hr.

For *transmission* personnel, we used the adjusted health information technician wage of $46.42/hr.

For *coding functions* we calculated a blended rate of $61.68/hr; this was the average of the adjusted hourly rates for RNs ($76.94/hr) and health information technicians ($46.42/hr). The blended rate reflects the fact that SNF providers have historically used both RN and support staff for the data entry function.

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Assumptions

According to the On-Line Survey and Certification System (OSCAR), there were approximately 15,472 skilled nursing facilities in FY 2021. Based on our SNF monitoring information, there were approximately 1,659,446 5-day scheduled PPS assessments and 1,582,855 discharge assessments completed and submitted by Part A SNFs in 2021. Based on FY 2021 data, an Interim Payment Assessment (IPA) was completed for approximately 4% of patients admitted for a Part A PPS stay have, resulting in 129,692 IPAs completed.

We estimate that the total number of 5-day scheduled PPS assessments, IPAs, and PPS discharge assessments that would be completed under the PDPM across all facilities is 3,371,993 (1,659,446 + 129,692 + 1,582,855, respectively). _

Collection of Information Requirements and Associated Burden Estimates

Based on our understanding of the MDS 3.0 and after discussions with clinicians, we estimate that it will take 51 minutes (.85 hours) to complete a single PPS Assessment. This can be broken down in the following way: It takes 40 minutes (0.6667 hours) to collect the information necessary for coding a PPS Assessment, 10 minutes (0.1667 hours) to code the responses, and 1 minutes (0.0167 hours) to transmit the results.

The total estimated time for MDS 3.0 PPS Assessment preparation and coding across all facilities is 2,866,194 hours per year (3,371,993 assessments x 0.85 hours).

MDS 3.0 PPS Item Set Preparation, Coding and Transmission

Total Number of Assessments Reporting	Completion time per assessment	Number of Respondents	Total Annual Hour Burden Across Facilities per year
3,371,993	0.85 hours	15,472	2,866,194

There were 15,472 skilled nursing facilities which sought reimbursement under the year-to-date projected SNF PPS during FY 2022. Under PDPM and SNF QRP, the cost per facility is $13,507 ($209,974,005/15,472 facilities) (see below).

MDS Preparation, Coding and Transmission	Total Minutes Per Respondent	Estimated Cost Per Respondent per Assessment	Annual Cost Burden Across Facilities (3,371,993 Assessments per year *cost per Assessment)	Annual Cost Burden Per Facility (annual cost across facilities/# of facilities)*

Preparation	40	$51.20	$172,646,042	$11,159
Coding	10	$10.30	$34,731,528	$2,245
Transmission	1	$0.77	$2,596,435	$168
TOTAL	51	$62.27	$209,974,005	$13,572

**Rounding was not done until the last step.*

Basic Requirements for all Claims. In evaluating the impact of billing changes in the UB-04 common claim form (approved by OMB under control number 0938-0997) our long-standing policy is to focus on changes in billing volume.

Summary of Requirements and Annual Burden Estimates

Requirement	Respondents	Responses (per respondent)	Total Responses (Respondents *Responses)	Time per Response (hr)	Total Time (hr) (Total Responses * Time per Response	Cost per Response	Total Cost ($) (Total Responses *Cost per Response)
5-day scheduled PPS Assessment	15,472	107.26	1,659,446	0.85	1,410,529	$62.27	103,333,702.42
PPS Discharge	15,472	102.30	1,582,855	0.85	1,345,427	$62.27	98,564,380.85
IPA	15,472	8.38	129,692	0.85	110,238	$62.27	8,075,920.84
TOTAL	15,472	217.94	3,371,993	0.85	2,866,194	$62.27	209,974,004.11

Information Collection/Reporting Instruments and Instruction Guidance Documents

The Information Collection/Reporting Instruments for the PDPM and SNF QRP effective 10/1/2023 are the MDS 3.0 forms/Item Sets: NP, NPE, IPA.

- NP PPS (NP) Version 1.18.11 effective 10/1/2023 (Revised, see the Crosswalk and section 15 for details)
- NPE Part A PPS Discharge (NPE) Version 1.18.11 effective 10/1/2023 (Revised, see the Crosswalk and section 15 for details)
- IPA Version 1.18.11 effective 10/1/2023 (Unchanged, see section 15 for details)
- LTC RAI User's Manual (Cover Only) (Revised, see the Crosswalk and section 15 for details) found at: https://downloads.cms.gov/files/1-MDS-30-RAI-Manual-v1-16-October-1-2018.pdf)

Additional SNF QRP Programmatic Burden

As requested by OMB, CMS acknowledges there is SNF QRP programmatic burden associated with other data collection methods, including the Centers for Disease Control's (CDC) National Healthcare Safety Network (NHSN).

The FY 2022 SNF PPS final rule (86 FR 42424) requires that SNFs submit data on the COVID-19 Vaccination Coverage among HCP measure beginning with the FY 2023 SNF QRP. However, this collection of information request does not set out such burden since the burden for collecting and reporting vaccination data is waived from the requirements of the PRA under

section 321 of the National Childhood Vaccine Injury Act (NCVIA) (Pub. L. 99-660). Section 321 can be found in a note at 42 U.S.C. 300aa-1.

The FY 2023 SNF PPS final rule (87 FR 47502) requires that SNFs submit data on the Influenza Vaccination Coverage among HCP measure beginning with the FY 2024 SNF QRP. However, this collection of information request does not set out such burden since the burden for collecting and reporting vaccination data is waived from the requirements of the PRA under section 321 of the National Childhood Vaccine Injury Act (NCVIA) (Pub. L. 99-660). Section 321 can be found in a note at 42 U.S.C. 300aa-1.

13. Capital Costs (Maintenance of Capital Costs)

Facilities are currently required to collect, compile, and transmit MDS data. Therefore, there are no capital costs. Any other cost can be considered a cost of doing business.

14. Cost to Federal Government

The Department of Health & Human Services (DHHS) will incur costs associated with the administration of the SNF quality reporting program including costs associated with the IT system used to process SNF submissions to CMS and analysis of the data received. CMS has engaged the services of an in-house CMS contractor to create and manage an online reporting/IT platform for the MDS. This contractor works with the CMS Center for Clinical Standards and Quality, Division of Post-Acute and Chronic Care (DCPAC) in order to support the IT needs of multiple quality reporting programs. When SNF providers transmit the data contained within the MDS to CMS it is received by this contractor. Upon receipt of all data sets for each quarter the contractor performs some basic analysis which helps to determine each provider's compliance with the reporting requirements of the SNF QRP. The findings are communicated to the SNF QRP lead in a report. Contractor costs include the development, testing, roll-out, and maintenance of the Resident Assessment Validation and Entry System (jRAVEN) that is made available to SNF providers free of charge providing a means by which SNFs can submit the required quality measure data to CMS. DCPAC had also retained the services of a separate contractor for the purpose of performing a more in-depth analysis of the SNF quality data, as well as the calculation of the quality measures, and future public reporting of the SNF quality data. Said contractor will be responsible for obtaining the SNF quality reporting data from the in-house CMS contractor. They will perform statistical analysis on this data and prepare reports of their findings, which will be submitted to the SNF QRP lead. DCPAC has retained the services of a third contractor to assist us with provider training and support services related to the SNF QRP. In addition to the contractor costs, the total includes the cost of the following Federal employees: GS-13 (locality pay area of Washington-Baltimore-Northern Virginia) at 100% effort for 3 years, or $297,516. GS-14 (locality pay area of Washington-Baltimore-Northern Virginia) at 33.33% effort for 3 years, or $117,191. The estimated cost to the federal government for the contractor is as follows:

CMS in-house contractor – Maintenance and support of IT platform that supports the MDS	$750,000
Data analysis contractor	$1,000,000
Provider training & helpdesk contractor	$1,000,000

GS-13 Step 1 Federal Employee (100% X 3 years at $99,172 annually)	$297,516
GS-14 Step 1 Federal Employee (33.33% X 3 years at $117,191 annually)	$117,191
Total cost to Federal Government:	**$3,164,707**

15. Program Changes

In the last 3 years, the number of SNFs has remained relatively stable. However, under the SNF PPS, there has been a reduction in billing volume in those same 3 years. In 2019, SNF care was the most common type of PAC, used after 18.7 percent of inpatient discharges. In March 2020, at the onset of the COVID-19 public health emergency, the share of inpatient hospital discharges referred to SNFs declined to 16.6 percent and by October 2020 had reached 14.9 percent.[4] Additionally, the number of Medicare beneficiaries enrolled in Medicare Advantage plans has increased from 21.9 million in 2019 (37%) to 26.4 million (45%) in 2021. These patients frequently have shorter lengths of stay and may not trigger the completion of an MDS assessment. As a result, the total number of assessments reported in this ICR reflects a decrease from the previous ICR. In this supporting statement, we also updated the salary estimate using the U.S. BLS from May 2018 to May 2020, and reflected such wage updates in burden estimates.

These updates resulted in the following changes to the current burden estimate:

- The last approved package estimated 4,905,042 assessments from 15,471 SNFs.
- This ICR estimates 3,371,993 assessments from 15,472 SNFs, a decrease of 1,533,049 assessments.
- The last approved package used U.S. BLS data from May 2018 for Health Information Technicians and Registered Nurses at an adjusted hourly wage of $43.32 and $72.60, respectively.
- This ICR used U.S. BLS data from May 2020 Health Information Technicians and Registered Nurses at an adjusted hourly wage of $46.42 and $76.94 respectively, an increase of $3.10 and $4.34 respectively.

As a result of these changes, the total annual hour burden across facilities has declined by 1,303,092 hours (4,169,286 minus 2,866,194), and the annual cost burden across facilities has declined by $77,902,910 ($287,876,915 minus $209,974,005).

We will also be updating the data submission system to the iQIES for the SNF QRP once it becomes available. This designation is a replacement of the existing QIES ASAP data submission system and imposes no additional requirements or burden on the part of SNFs.

16. Publication and Tabulation Dates

Not applicable.

17. Expiration Date

The PRA Disclosure statement can be found in the Downloads section on the CMS Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual webpage at:

[4] Health care spending and the Medicare program: A Data Book. Chapter 8: Post-Acute Care Services. MedPAC. July 2022.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

18. Certification Statement

There are no exceptions.

C. Collection of Information Employing Statistical Methods

In collecting the data for payment and quality purposes, we do not employ any statistical sampling methods.

APPENDIX A:
MDS 3.0 ITEM SET V1.18.11 ASSOCIATED CHANGE TABLE

See attached MDS 3.0_Item Set Change History_v1.18.11 October 2023.pdf, titled *MDS 3.0 Item Set Change History for October 2023 Version 1.18.11*.

APPENDIX B:
GLOSSARY

ASAP: Assessment Submission and Processing
CDC: Centers for Disease Control & Prevention
CMS: Centers for Medicare & Medicaid Services
DCPAC: Division of Post-Acute and Chronic Care
DHHS: Department of Health & Human Services
FY: Fiscal Year
IOM: Institute of Medicine
IPA item set: Interim Payment Assessment item set
iQIES: Internet Quality Improvement and Evaluation System
IT: Information Technology
jRAVEN: Resident Assessment Validation and Entry System
LTC: Long-Term Care
MDS: Minimum Data Set
NC item set: Nursing Home Comprehensive assessment item set
ND item set: Nursing Home PPS Discharge item Set
NH: Nursing Home
NHSN: National Healthcare Safety Network
NO item set: Nursing Home OMRA item set
NOD item set: Nursing Home End of Therapy OMRA combined with Discharge assessment item set
NP item set: Nursing Home PPS 5-day item set
NPE item set: Nursing Home PPS Discharge item set
NQ item set: Nursing Home Quarterly item set
NQF: National Quality Forum
NS item set: Nursing Home Start of Therapy OMRA item set
NSD item set: Nursing Home Start of Therapy OMRA combined with Discharge assessment item set
NT item set: Nursing Home Tracking item set
OBRA: Omnibus Reconciliation Act of 1987
OMB: Office of Management and Budget
OMRA: Other Medicare Required Assessment
OSCAR: On-Line Survey and Certification System
PDPM: Patient Driven Payment Model
PHE: Public Health Emergency
PPS: Prospective Payment System
PRA: Paperwork Reduction Act

QIES: Quality Improvement and Evaluation System
QRP: Quality Reporting Program
RAI: Resident Assessment Instrument
RN: Registered Nurse
SD item set: Swing Bed PPS Discharge item set
SNF: Skilled Nursing Facility
SO item set: Swing Bed OMRA item set
SOD item set: Swing Bed End of Therapy OMRA combined with Discharge assessment item set
SP item set: Swing Bed PPS 5-day item set
SS item set: Swing Bed Start of Therapy OMRA item set
SSD item set: Swing Bed Start of Therapy OMRA combined with Discharge assessment item set
ST item set: Swing Bed Tracking item set
TOH Information: Transfer of Health Information
UB-04: Universal Bill Form 04